Wakefulness Promoting Agents

Nuvigil (armodafinil), Provigil (modafinil), Sunosi (solriamfetol), Wakix (pitolisant)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED PROVIDER LETTER TO 855-828-4992

Criteria for Approval: Circle the diagnosis and medication. *(must submit chart notes indicating one of the following diagnosis)*

Diagnosis, Dose and Age Limitations	**Provigil (modafinil)** *18 yrs. or older*	**Nuvigil (armodafinil)** *18 yrs. or older*	**Sunosi (solriamfetol)** *18 yrs. or older*	**Wakix (pitolisant)** *18 yrs. or older*
Daytime somnolence due to obstructive sleep apnea	200mg/day	150 mg/day	150mg/day	
Narcolepsy	400mg/day	250mg/day	150mg/day	35.6mg/day
Narcolepsy with cataplexy				35.6mg/day
Sedation related to multiple sclerosis treatment	200mg/day			
Shift work sleep disorder	200mg/day	150 mg/day		

Additional criteria for daytime somnolence due to obstructive sleep apnea:

- ❑ Patient must use CPAP or prescriber must submit appropriate clinical rationale for not using CPAP:
  _____ Chart Note Page #: _____

Additional criteria for shift work sleep disorder: *All criteria must be met*

- ❑ Documentation demonstrating excessive sleepiness at work and insomnia when the patient should be sleeping.
- ❑ Documentation indicating member is working night shifts.

Additional criteria for Sunosi and Wakix:

- ❑ Trial and Failure of modafinil and/or armodafinil:
  Medication: _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____

Re-authorization Criteria:

- ❑ Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.
- ❑ For daytime somnolence due to obstructive sleep apnea, patient should continue on CPAP or explanation for discontinuation.
- ❑ For shift work sleep disorder, patient must still be working night shifts.

Initial Authorization: Up to 6 months
Re-authorization: Up to 1 year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date